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Understanding Health Reform

Commonly Used Terms in Health Reform

The Affordable Care Act was passed by Congress and signed into law by President Obama on March 23, 2010. The comprehensive health care reform has a number of changesthat will affect you, your family, and your friends. Implementation of health care reform will help make healthcare more affordable; make health insurers more accountable; expand access to health care coverage to more Americans; and contribute to making the health system more sustainable, by helping to stabilize family budgets, the Federal budget, and the economy.

To help you understand the changes that are happening now and in the near future, we want to make sure you understand the terminology being used. Health care coverage is complex enough, and you shouldn't be confused by some of the more common health care terms. Below, you will find a glossary of such terms.

What do all these terms mean?

Accountable Care Organization
A network of health care providers that agrees to be accountable for the quality, cost, and overall care of specific patients. New pilot programs in Medicare and Medicaid, established by the Affordable Care Act, would provide financial incentives for these organizations to improve quality and reduce costs by allowing them to share in any health care savings achieved as a result of these efforts.

Allowed Charge for a Covered Service
The maximum dollar amount that a third party, usually an insurance company, will reimburse a provider for a specific covered service.

Annual Limit
A cap on the benefits your insurance company will pay in a year while you're enrolled in a particular health insurance policy. These annual caps are sometimes placed on particular services, such as prescriptions or hospitalizations. Annual limits may be placed on the dollar amount of covered services and/or on the number of visits that will be covered for a particular type of service. After an annual limit is reached, you must pay all such health care costs for the remainder of the year.

Appeal
A request for your health insurer or plan or an outside party to review a decision made or to review action on a grievance filed.




Benefits
The health care items or services covered under a health plan. (See, also, "Covered Services.") Covered benefits and excluded services are defined in the health plan's coverage documents. For Medicaid and Children's Health Insurance Programs (CHIP), covered benefits and excluded services are defined in the applicable State program rules. For more information, please visit http://www.healthcare.gov.

Care Coordination
The organization of your treatment by or among several different health care providers. Medical homes and Accountable Care Organizations are examples of ways to improve care coordination.

Children's Health Insurance Program (CHIP)
An insurance program jointly funded by State and Federal governments (and administered by States in conformance with Federal requirements) that provides health insurance to low-income children and, in some States, pregnant women in families who earn too much income to qualify for Medicaid but who cannot afford to purchase private health insurance coverage.

Chronic Disease Management
An integrated care approach to managing chronic health problems, which is focused on prevention and maintenance and includes screenings, check-ups, monitoring, coordinating treatment, and patient education. It can help improve your quality of life, while reducing your health care costs if you have a chronic disease by potentially preventing or minimizing the effects of a disease and by promoting earlier and more effective recovery.

Claim
A request for payment that you or your health care provider submits to your health insurer or plan for covered items or services.

COBRA
The Consolidated Omnibus Reconciliation Act of 1985 (COBRA) is a Federal law that may allow you to temporarily keep job-based health coverage after certain qualifying events, such as your employment ends, or you lose coverage as the spouse or dependent of the covered employee. If you elect COBRA coverage, you can be charged 100% of the premiums (the cost of the health coverage), including the share the employer used to pay, plus a small administrative fee. For more information, please go to http://www.dol.gov and search COBRA. COBRA may last only for 18 to 36 months.

Coinsurance
The percentage of allowed charges for covered services that you're required to pay. For example, the health insurance plan may cover 80% of charges for a covered hospitalization, leaving you responsible for the other 20%. This 20% is known as the coinsurance.

Copayment
A flat dollar amount you must pay as your part of the payment for a covered service. For example, you may have to pay a $15 copayment for each covered visit to a primary care doctor or a specialist.




Cost Sharing
The share of costs for Covered Services that you pay out of your own pocket. This term generally includes deductibles, coinsurance, and copayments, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. However, cost sharing in Medicaid and CHIP also includes premiums.

Covered Services
Those health care services that you are entitled to receive under the terms and conditions of a health plan.

Deductible
The amount you must pay out-of-pocket each year or policy period for Covered Services before your health insurance begins to pay.

Dependent Coverage
Insurance coverage for qualified family members of the policyholder, such as spouses, children, or partners.

Donut Hole, Medicare Prescription Drug
Most plans with Medicare prescription drug coverage (Part D) have a coverage gap (sometimes called a "donut hole"). This means that, after you and your plan have spent a certain amount of money for covered prescription drugs, you have to pay all costs out-of-pocket for your covered prescription drugs up to a yearly limit. Once you have spent up to that limit, your coverage gap ends and your plan helps pay for covered drugs again.

Essential Health Benefits
A set of health care service categories that must be covered by certain plans starting in 2014. These include doctor office visits, prescription drugs, hospitalization, and mental health and substance use disorder benefits. Insurance policies must cover these benefits to be certified and offered in Exchanges, and all Medicaid State plans must cover these services by 2014.

Exchange (or Health Insurance Exchange)
An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality.

Exclusions
Items or services that aren't covered under your health plan and for which the plan won't pay. For example, your health plan might not cover certain services that are considered experimental or services related to a pre-existing condition (if permitted by law).

Federal Poverty Level
Income thresholds determined by the U.S. Department of Health and Human Services that are used to determine your eligibility for certain programs and benefits. You can find the Federal Poverty Guidelines at http://aspe.hhs.gov/poverty/

Fee for Service
A method in which doctors and other health care providers are paid for each service performed. Examples of services include tests and office visits.

Insured Job-based Plan
A health plan sponsored by an employer in which some or all of the benefits are covered by an insurance policy and for which the insurance company—and not the employer—is at risk for the cost of the benefits.




Grandfathered Health Plans
As used in connection with the Affordable Care Act, the term "grandfathered health plan" refers to a group health plan that was created (or an individual health insurance policy that was purchased) on or before March 23, 2010. Grandfathered plans are exempt from many changes required under the Affordable Care Act. Plans or policies may lose their "grandfathered" status if they make certain significant changes that reduce benefits or increase costs to consumers. A health plan must disclose in its plan materials whether it considers itself to be a grandfathered plan and must also advise consumers how to contact the U.S. Department of Labor or the U.S. Department of Health and Human Services with questions. (Note: If you are in a group health plan, the date you joined may not reflect the date the plan was created. New employees and new family members may be added to grandfathered group plans after March 23, 2010.)

Grievance
A complaint that you communicate to your health insurer or plan (concerning access to care or the quality of care provided).

Group Health Plan
Health coverage offered in connection with employment. Also called job-based health coverage.

Guaranteed Issue
A requirement that health plans must permit you to enroll regardless of health status, age, gender, or other factors that might predict the use of health services. Except in some States, guaranteed issue doesn't limit how much you can be charged if you enroll.

Guaranteed Renewal
A requirement that your health insurance issuer must offer to renew your policy as long as you continue to pay premiums. Except in some States, guaranteed renewal doesn't limit how much you can be charged if you renew your coverage.

Health Homes
Under the Affordable Care Act, States have the option to provide medical assistance under Medicaid to eligible individuals with chronic conditions who select a designated provider, a team of health care professionals operating with such a provider, or a health team as the individual's health home for purposes of providing the individual with health home services, including the coordination of care. Accordingly, a health home is not a physical home, but refers to the provider or team of health care professionals.

Health Maintenance Organization (HMO)
A type of health insurance plan in which all care must usually be obtained from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.

Health Status
Refers to your medical conditions (both physical and mental health), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability and disability.




Home and Community-based Services
Services and support provided by most State Medicaid programs in your home or community that help with such daily tasks as bathing or dressing. This care is covered when provided by care workers or, if your State permits it, by your family.

Individual Health Insurance Policy
A health insurance policy that is not sold in connection with employment. It can cover an individual and family. It does not refer to government health insurance programs such as Medicaid and Medicare. Individual health insurance policies are regulated under State law.

Lifetime Limit
A cap on the total lifetime benefits you may get from your insurance company. An insurance company may impose a total lifetime dollar limit on benefits (like a $1 million lifetime cap) or limits on specific benefits (like a $200,000 lifetime cap on organ transplants or one gastric bypass per lifetime) or a combination of the two. After a lifetime limit is reached, the insurance plan will no longer pay for covered services. Lifetime limits are generally no longer permitted under the Affordable Care Act.

Long-term Care
Services that include medical and non-medical care provided to people who are unable to perform basic activities of daily living, such as dressing or bathing. Long-term support and services can be provided at home, in the community, in assisted living facilities, or in nursing homes. Individuals may need long-term support and services at any age. Medicare and most health insurance plans don't pay for long-term care.

Medicaid
A State-administered health insurance program for low-income families and children, pregnant women, the elderly, people with disabilities, and, in some States, other adults. The Federal Government provides a portion of the funding for Medicaid and sets guidelines for the program. States also have choices concerning how they design their program, so Medicaid varies State by State and may have a different name in your state. For more information on Medicaid, please visit http://www.healthcare.gov, click "Find Insurance Options," and follow the directions from there.

Medicare
A Federal health insurance program for people who are age 65 or older and certain younger people with disabilities. It also covers people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD). For more information, please go to http://www.Medicare.gov.

Medicare Advantage (Medicare Part C)
A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage.




Medicare Part D
A program that helps pay for prescription drugs for people with Medicare who join a plan that includes Medicare prescription drug coverage. There are two ways to get Medicare prescription drug coverage: through a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes drug coverage. These plans are offered by insurance companies and other private companies approved by Medicare.

Minimal Essential Coverage
The type of coverage an individual needs to have to meet the individual responsibility to have minimum insurance coverage as required under the Affordable Care Act. Minimum Essential Coverage can be acquired through individual market insurance policies, job-based insurance coverage, Medicare, Medicaid, CHIP, TRICARE, and certain other coverages.

Network
The providers (including physicians, hospitals, and any other providers) with which your health plan has arrangements for purposes of providing covered services under the terms of the health plan.

Non-Preferred Provider
A provider who does not have an arrangement with your health insurer or plan to provide covered services to you. You may pay more to see a non-preferred provider. If your health insurer or plan offers you coverage for services provided by both preferred providers (in-network providers) and non-preferred providers (out-of-network providers), it will likely cost less if you go to a preferred provider.

Open Enrollment Period
A period of time that may be available, usually once a year, when you can enroll or change an enrollment in a health plan. It is different from the first chance you have to enroll (for example, when you start a new job) or the special enrollment period you get if you have a qualifying change in life status, such as getting married or divorced or moving to a new job (see Special Enrollment Period).

Out-of-Pocket Costs
Your expenses for medical care that aren't reimbursed by insurance. Out-of-pocket costs include Cost Sharing, such as deductibles, coinsurance, and copayments for Covered Services, in addition to costs for services that aren't Covered Services.

Plan Year/Policy Year
A 12-month period of benefits coverage under a group health plan. This 12-month period may not be the same as the calendar year. To find out when your plan year begins, you can check your plan documents or ask your employer. (Note: For individual health insurance policies, this 12-month period is called a "policy year".)

Point-of-Service (POS) Plan
A type of plan in which you pay less if you use doctors, hospitals, and other health care providers that belong to the plan's network. POS plans also require you to get a referral from your primary care doctor in order to see a specialist.




Preauthorization
A decision by your health insurer or plan that health care products and/or services are medically necessary. This process may also be referred to as prior authorization, prior approval, or precertification. Your health insurer or plan may require preauthorization for certain services before you can receive them.

Pre-existing Condition (Individual Policy)
A condition, disability, or illness (either physical or mental) that you have before you're enrolled in a health plan. This term is defined under State law and varies significantly by State. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition.

Pre-existing Condition (Job-based Group Coverage)
Any condition (either physical or mental) including a disability for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on your enrollment date in a health insurance plan. Genetic information, without a diagnosis of a disease or a condition, cannot be treated as a pre-existing condition. Pregnancy cannot be considered a pre-existing condition, and newborns, newly adopted children, and children placed for adoption who are enrolled within 30 days cannot be subject to pre-existing condition exclusions.

Pre-existing Condition Exclusion Period (Individual Policy)
The time period during which an individual policy won't pay for care relating to a pre-existing condition. Under an individual policy, conditions may be excluded permanently (known as an "exclusionary rider"). Rules on pre-existing condition exclusion periods in individual policies vary widely by State.

Pre-existing Condition Exclusion Period (Job-based Group Coverage)
The time period during which a health plan won't pay for care relating to a pre-existing condition. Under a job-based group plan, this usually cannot exceed 12 months.

Pre-existing Condition Insurance Plan
A program under the Affordable Care Act that will provide a health coverage option for you if you have been uninsured for at least 6 months, you have a pre-existing condition, and you have been denied coverage (or offered insurance without coverage of the pre-existing condition) by a private insurance company. This program will provide coverage until 2014 when you will have access to affordable health insurance choices through an Exchange, and you can no longer be discriminated against based on a pre-existing condition. For more information go to http://www.healthcare.gov.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide Covered Services to you.

Preferred Provider Organization (PPO)
A type of health plan that contracts with medical providers, such as hospitals and doctors, to create a network of participating providers. You pay less if you use providers that belong to the plan's network. You can use doctors, hospitals, and providers outside of the network for an additional cost.




Premium
A monthly payment made in order to get and keep health coverage. Premiums can be paid by employers, unions, employees, or non-employee individuals or shared among different payers.

Preventive Services
Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care
Health services that cover a range of preventive services and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with you and advise and treat you on a range of health-related issues. They may also coordinate your care with specialists.

Qualified Health Plan
Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Exchange in which it is sold.

Rate Review
A process by which State insurance regulators review premium increases imposed by insurance companies.

Rescission
The retroactive cancellation of a health insurance policy. Insurance companies will sometimes retroactively cancel your entire policy if you made a mistake or unintentionally misrepresent your medical condition on your initial application when you buy an individual market insurance policy. Under the Affordable Care Act, rescission is not permitted except in cases of fraud or intentional misrepresentation of a material fact as prohibited by the terms of the plan or coverage.

Self-Insured Plan (also referred to as a "Self-Funded Plan")
Type of plan in which an employer, rather than an insurance company, assumes the risk for employees' and dependents' medical claims. Self-Insured Plans often contract with an insurance company or a third party administrator to administer the benefits.

Special Enrollment Period
A period of time outside of the open enrollment period during which you and your family have a right to enroll in job-based health plans. Job-based health plans must provide a special enrollment period of 30 days following certain qualifying life events that involve a change in family status (for example, marriage, birth of a child, or aging out of dependent coverage) or loss of other job-based health coverage.




Where can I find more information on Health Reform?

The Affordable Care Act was passed by Congress and signed into law by President Obama on March 23, 2010; the comprehensive health care reform has a number of changes that will affect you, your family, and your friends. There are a number of resources available to help you find information about the Affordable Care Act. Some resources available are:

- http://www.healthcare.gov
- http://www.samhsa.gov/healthreform
- http://blog.samhsa.gov
- http://www.hhs.gov
- http://www.ncsl.org

The most comprehensive resource available is the Federal Government's new Web site http://www.healthcare.gov. Healthcare.gov provides you with a number of resources. On healthcare.gov you can:

- Find and compare health care coverage options in your State, including Medicaid services.
- Access information and timelines about the different provisions in the Affordable Care Act.
- Compare care quality of hospitals.
- Learn about health prevention and get prevention tips.

If you want to know more about your rights under the Affordable Care Act, go to: http://www.healthcare.gov/law/provisions/billofright/patient_bill_of_rights.html.

Specialist
A physician specialist focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

State Continuation Coverage
A State-based requirement similar to COBRA that applies to group health insurance policies of employers with fewer than 20 employees. In some States, State continuation coverage rules also apply to larger group insurance policies and add to COBRA protections. For example, in some States, if you're leaving a job-based plan, you must be allowed to continue your coverage until you reach the age of Medicare eligibility.

TRICARE
TRICARE is a health care program of the U.S. Department of Defense Military Health System. TRICARE provides civilian health benefits for military personnel, military retirees, and their dependents, as well as some members of the Reserve Component. For more information on TRICARE, please visit http://www.tricare.mil.

Uncompensated Care
Health care or services, which are provided by hospitals or other types of health care providers, that don't get reimbursed. Uncompensated care often arises when people don't have insurance and/or cannot afford to pay the cost of care.

Waiting Period (Job-based Coverage)
The time that must pass before coverage can become effective for an employee or qualified dependent who is otherwise eligible for coverage under a job-based health plan.